Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 06/21/01 through 10/09/01.
   b. The request was received on 03/20/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. EOBs
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/21/02. The response from the insurance carrier was received in the Division on 09/03/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Note on Table of Disputed Services
   "Visits were approved, company does not want to pay."

2. Respondent: Letter dated 09/03/02

"The (Carrier) was in receipt of the requestor's submitted billing for the dates of service 06/21/01 through 10/09/01 listed on the Table of Disputed Services, after being reviewed it was determined that the documentation did not support the services billed and were denied using the exception code 'N72; Not Documented Documentation must include treatment provided with days of the week , response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan.'."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 06/21/01 through 10/09/01. Dates of service 08/15/01, 09/18/01, and 09/25/01 will be addressed in the Dismissal Section of this Findings and Decision.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. The provider failed to total the amount in dispute on the Table of Disputed Services, therefore, the Medical Dispute Officer calculated the total amount billed as $4,489.00; the amount paid as $0.00; the total amount in dispute as $4,489.00.

3. On the Table of Disputed Services, several dates of services and CPT codes were duplicated and will not be addressed.

4. The carrier denied the billed services by codes:
"D - Duplicate Charge";
"N10 – Not Documented. A report and/or Documentation of Procedure is required for consideration of the charge(s) as billed. Please forward necessary documentation to to the carrier.";
"O – Upon review of your request for a reconsideration, no additional benefits is recommended at this time.";
"N72 – Not Documented. Documentation must include treatment provided (with days of week) response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan.";
"Z1 – Pre-Authorization required under 134, Provider did request and the request was denied.";
"N3 – Documentation does not adequately identified/qualified services or supplies billed.";
"F – Reduced According to Fee Guideline.";
"N11 – Not documented, upon review, documentation as submitted does not support the level of service(s) billed.";
"N75 – Not Documented. Upon review, documentation as submitted does not support the procedure billed.";
"A – Pre-Authorization Not Obtained.";
"F70 – Reduction According to Fee Guideline. Exceeds the limitations of the Physical Medicine Ground Rules.";
"N – Not Appropriately Documented.";
"A1 – Pre-Authorization required under 134, But [sic] the provider did not request for Pre-Authorization."

5. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
06/21/01 06/26/01 06/27/01 07/16/01 07/17/01 08/06/01 08/07/01 08/13/01 08/21/01 09/04/01 09/11/01 09/26/01 10/09/01	99213	$45.00	$0.00	N,D,F,O N,D N,D,O N,D N,D N,D N,D N,D N,D,O N,D,F,O N,D,F,O N,D,F,O N,D	$48.00	MFG E/M GR (IV) (A); (C) (2); (VI) (B); Rule 133.1 (a) (E) (i); CPT descriptor	MFG E/M GR (IV) (A) introduces the levels of services which encompass wide variations of skill, effort, time, responsibility, and knowledge required to treat the diagnosis of claimant's illnesses and injuries. The services can include examinations, evaluations, treatments, counseling, and conferences with or concerning the patient. MFG MGR (IV) (C) (2) states, "**TWO OF THE THREE KEY COMPONENTS** shall meet or exceed the stated requirements to qualify for a particular level of E/M service: office…" CPT code 99213 descriptor states, "Office…visit for the evaluation and management of an established patient, (reference MFG E/M VI B) which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity...Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family." Rule 133.1 (a) (E) (i) requires that all supporting documentation be legible and include "for the three highest level of office visits…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" The provider' documentation for the dates of service in dispute do not meet the criteria of the 99213 CPT code descriptor criteria. The documentation for services in dispute do not substantiate the level of service for which the provider billed. The medical documentation for the disputed DOS do not reflect a patient treatment plan or the overall progress of the patient. (Some of the daily notes are difficult to read.) The notes do not reflect the patient's response to the long-term treatment or the **overall improvement** of symptoms. The notes do not document subjective and objective assessments. The notes do not indicate the next date of treatment or service nor the patient's overall, long-term progress. The treatment is not evaluated for effectiveness nor modified based on the patient's reaction to the treatment. No re-evaluations of the treatment are documented in the notes. DOS 06/21/01 states, "…pt. feeling better…improving in C-spine, little sore tolerating exercise program well." DOS 06/27/01 states, "…feeling better from yesterday Exercise plan going well." DOS 07/16/01 states, "…exercise program, ↑ Strength ↑ ROM." DOS 08/06/01, 08/13/01 and 08/14/01 report the same statement. 08/28/01 notes, "…therapeutic exercises 2/10 lumbar pain, ROM-lumbar restored to normal" On 09/11/01, the patient participated in "therapeutic exercises", but experienced "lumbar pain ↓ ROM…" 10/09/01 notes that the "Pt. doing well. No pain no ROM problems." No reimbursement is recommended.

06/21/01 06/26/01 06/27/01 07/16/01 07/17/01 08/06/01 08/07/01 08/13/01 08/21/01 09/04/01 09/11/01 09/26/01 10/09/01	97265	$43.00	$0.00	N,D,O N,D,,O N,D,O N,D N,D,O N,D,O N,D,O,Z1 N,D,O,A 1 N,D,O N,D,O,F N,D,O,F N,D,O,F N,D,O	$43.00	MFG MGR (I) (A) (9) (c); (10) (a); Rule 133.1 (a) (E) (i); Rule 134.600 (h) (10); CPT descriptor	The MFG MGR (I) (A) (9) (c) indicates "Physical Medicine Activities and Training (Supervision by the doctor or HCP is required): 97220-97541…" The CPT descriptor for 97265 is "Joint mobilization, one or more areas (peripheral or spinal)". ." (10) (a) indicates "A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541)…" Rule 133.1 (a) (E) (i) requires that that all supporting documentation be legible and include "for the three highest level of office visits…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" Rule 134.600 (h) (10) requires pre-authorization after 8 weeks of treatment. DOS 08/07/01& 08/13/01: One of the denial codes for these DOS is a pre-authorization issue. The medical dispute information submitted by both parties does not include any request for or denial of pre-authorization documentation. The patient's 8 weeks of physical medicine sessions began 3-16-01 and ended 05/10/01. These DOS are beyond the 8 weeks of therapy without pre-authorization. For each DOS, the provider documents the abbreviation "Adj" in the notes. The documentation do not include a legend for the abbreviations, although the interpretation by the Medical Review Officer is that "Adj" indicates "Adjustment" or "Joint Mobilization". The provider fails to state the adjustment of what body area or part, if the joint mobilization provides any improvement to the patient's injury, or if any complications arise from the joint mobilization. The provider did not indicate a subjective or objective assessment of the area of adjustment or if the joint mobilization assisted in the patient's progress or improvement. The treatment is not evaluated for effectiveness nor modified based on the patient's reaction to the treatment. The documentation of services in dispute do not substantiate the level of service for which the provider billed. The documentation does not indicate the next date of treatment or service. The documentation does not reflect the patient's response to the long-term treatment or the **overall improvement** of symptoms. No reimbursement is recommended.
06/21/01 06/26/01 06/27/01 07/16/01 07/17/01 08/06/01 08/07/01 08/13/01 08/21/01 09/04/01 09/11/01 09/26/01 10/09/01	97110	$120.00	$0.00	N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O,Z1 N,D,O,A N,D,O N,D,O,F N,D,O,F N,D,O,F, A N,D,O	$35.00 per each 15 minute unit	MFG MGR (I) (A) (9) (b); (10) (a); (11) (a); Rule 133.1 (a) (E) (i); Rule 134.600 (h) (10); CPT descriptor	MFG MGR (I) (A) (9) b) states, "Procedures (Supervision by the doctor or HCP,…one-to-one (97110-97139) setting, is required)…" (10) (a) indicates "A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541)…" (11) (a) notes that "Therapeutic procedures (97110) is defined as therapeutic exercises used to develop strength and endurance, range of motion and flexibility. Examples include the use of graded resistance ranging from manual resistance to a variety of equipment including isokinetic, isometric, or isoinertial in one or more planes." DOS 08/07/01, 08/13/01, & 09/26/01: One of the denial codes for these DOS is a pre-authorization issue. The medical dispute information submitted by both parties does not include any request for or denial of pre-authorization documentation. The patient's 8 weeks of physical medicine sessions began 3-16-01 and ended 05/10/01. These DOS are beyond the 8 weeks of therapy without pre-authorization.

							Rule 133.1 (a) (E) (i) requires that that all supporting documentation be legible and include "for the three highest level of office visits…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" The provider mentions in the notes for each DOS, except 09/26/01 and 10/09/01, the words "exercise program, exercise plan, therapeutic exercises, exercises". In accordance with Rule 133.1 (a) (E) (i), the provider failed to indicate long-term progress, subjective or objective assessment of the treatment. Statements such as "tolerating exercise program well, exercise program going well" were noted in the medical documentation. Statements such as "tolerating exercise program well, exercise program going well" were also noted in the medical documentation. Other notations made in the medical documentation are "↑Strength, ↑ROM, ↑lumbar restored to normal ® leg short, ↓ ROM". The provider failed to indicate improvement from day to day or week to week. The provider did not indicate a subjective or objective assessment of the area of physical therapy or if the physical therapy assisted in the patient's progress or improvement. The physical therapy treatment is not evaluated for effectiveness nor modified based on the patient's reaction to the treatment. The documentation of services in dispute does not substantiate the level of service for which the provider billed. The documentation does not indicate the next date of treatment or service. The documentation does not reflect the patient's response to the long-term physical therapy treatment or the **overall improvement** of symptoms. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The provider fails to identify the types of activities/therapies the claimant is performing on each date of service, therefore, the notes do not support the time billed on each HCFA for the CPT code 97110. There is no documentation that claimant is performing the physical therapy sessions in a one-on-one setting. There are no direct statements as to who is conducting the sessions with the claimant. The medical document is not signed. There is no documentation that clearly indicates that the activities require one-on-one therapy sessions. The provider fails to document or substantiate any medical condition or symptoms which the claimant presents that mandates one-on-one supervision for an entire session. The notes do not reflect the need for one-on one supervision tapering off over time as the claimant becomes more familiar with the exercises. No reimbursement is recommended.

06/21/01 06/26/01 06/27/01 07/16/01 07/17/01 08/06/01 08/07/01 08/13/01 08/21/01 09/04/01 09/11/01 09/26/01 10/09/01	97035	$15.00	$0.00	N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O N,D,Z1 N,D,O,A, F N,D,O N,D,O,F N,D,O,F, N,D,O,F, A N,D,O	$22.00 per each 15 minute unit	MFG MGR (I) (A) (iii); (10) (a); Rule 133.1 (a) (E) (i); Rule 134.600 (h) (10); CPT descriptor	MFG MGR (I) (A) (iii) "Constant Attendance: the application of a modality that requires direct (one-to-one) patient contact by the provider. The codes are 97032-97039." (10) (a) indicates "A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541)…" Rule 133.1 (a) (E) (i) requires that that all supporting documentation be legible and include "for the three highest level of office visits…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" Rule 134.600 (h) (10) requires pre-authorization after 8 weeks of treatment. DOS 08/07/01, 08/13/01, & 09/26/01: One of the denial codes for these DOS is a pre-authorization issue. The medical dispute information submitted by both parties does not include any request for or denial of pre-authorization documentation. The patient's 8 weeks of physical medicine sessions began 3-16-01 and ended 05/10/01. These DOS are beyond the 8 weeks of therapy without pre-authorization. The only DOS that documents "ultra-sound" uses the abbreviation of "U/S" which this Medical Review Officer interprets as CPT code 97035, ultra-sound, is 07/17/01. The documentation does not include a legend for the abbreviation. The documentation does not reflect what body area the ultra-sound was administered. The remaining disputed DOS do not document that the patient received ultra-sound services as billed by the provider. There is no documentation to substantiate that the services were rendered as billed for all other DOS. The ultra-sound treatment is not evaluated for effectiveness nor modified based on the patient's reaction to the ultra-sound treatment. The documentation of the service in dispute does not substantiate the level of service for which the provider billed. The notes do not indicate the next date of treatment or service. The notes do not reflect the patient's response to the long-term treatment of using the ultra-sound or the **overall improvement** of symptoms. In accordance with Rule 133.1 (a) (E) (i), the provider failed to indicate long-term progress, subjective or objective assessment of the treatment. There are no direct statements as to who is conducting the one-on-one sessions with the patient's. The medical document is not signed. No reimbursement is recommended.

06/21/01 06/26/01 06/27/01 07/16/01 07/17/01 08/06/01 08/07/01 08/13/01 08/21/01 09/04/01 09/11/01 09/26/01 10/09/01	97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010 97014 97010	$15.00 $15.00	$0.00 $0.00	N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O N,D,O N,D,F N,D,O N,D,O,Z1 N,D,F,Z1 N,D,O,A N,D,O,A N,D,O N,D,O N,D,O,F N,D,O,F N,D,O,F N,D,O,F N,D,O,F, A N,D,O,F, A N,D,O N,D,O,F	$15.00 $11.00	MFG MGR (I) (A) (9) (a) (ii); (10) (a); Rule 133.1 (a) (E) (i); Rule 134.600 (h) (10); CPT descriptor	MFG MGR (I) (A) (9) (a) (ii) describes supervised modalities as "the application of a modality that does not require direct (one-to-one) patient contact by the provider. The codes are 97010-97028." (10) (a) indicates "A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541)…" Rule 133.1 (a) (E) (i) requires that all supporting documentation be legible and include "for the three highest level of office visits…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" Rule 134.600 (h) (10) requires pre-authorization after 8 weeks of treatment. DOS 08/07/01, 08/13/01, & 09/26/01: One of the denial codes for these DOS is a pre-authorization issue. The medical dispute information submitted from both parties does not include any request for or denial of pre-authorization documentation. The patient's 8 weeks of physical medicine sessions began 3-16-01 and ended 05/10/01. These DOS are beyond the 8 weeks of therapy without pre-authorization. Each disputed DOS does document "EMS" and "Ice", but the documentation does not include a legend. This Medical Review Officer interprets these abbreviations for electrical stimulation and application of ice packs. The provider fails to indicate what body area and where the services were applied. The documentation of services in dispute does not substantiate the level of service for which the provider billed. The documentation does not indicate the next date of treatment or service. The documentation does not reflect the patient's response or improvement to the electrical stimulation or the use of the ice pack over long-term usage. The documentation fails to address how the services affect the patient's symptoms throughout the treatment. The electrical stimulation and ice pack usage is not evaluated for effectiveness or by subjective or objective means. No reimbursement is recommended.
Totals		$3,289.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 15th day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

V. Dismissal

Dates of service 08/15/01, 09/18/01, and 09/25/01 are being dismissed. According to Commission Rule 133.307 (m), the Division may dismiss a request if the commission determines that good cause exists to dismiss the request. The insurance carrier denied these dates of service as "Not Documented". In accordance with Rule 133.1 (a) (E) (i), "A complete bill includes…legible supporting documentation…for the three highest level office visits,…physical medicine treatment(s) and/or services(s): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…" Rule 133.307 (g) (3) (B) states, "The commission shall …require the requestor to send to the commission,…additional documentation relevant to the fee dispute. The additional documentation shall include:…a copy of any pertinent medical records or other documents relevant to the fee dispute,…" The provider failed to submit any medical documentation for the above noted disputed dates of service.

This dismissal does not constitute a decision on these dates of service.